



**SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR
FOR CHRONIC HEPATITIS C
SPECIAL AUTHORIZATION REQUEST FORM**
Patients may or may not meet eligibility requirements as established by
Alberta government-sponsored drug programs.

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION				COVERAGE TYPE	
PATIENT LAST NAME	FIRST NAME	INITIAL		<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> Other	
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER				
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER	

PRESCRIBER INFORMATION					
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION		
			REGISTRATION NUMBER		
STREET ADDRESS			<input type="checkbox"/> CPSA <input type="checkbox"/> ACO <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other		
CITY, PROVINCE			PHONE	FAX	
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

1) Does the patient have a quantitative HCV RNA value within six months of this request?
 Yes → Provide test date (YYYY-MM-DD) _____ No Not tested

2) Does the patient have decompensated cirrhosis with Child-Turcotte-Pugh B or C (i.e. score seven or above)?
 Yes
 No

3) Has the patient previously been treated with an HCV antiviral drug regimen?
 No, the patient is treatment-naïve
 Yes → Specify drug regimen previously used _____
 → If the drug regimen utilized contained sofosbuvir *without* an NS5A inhibitor, is the patient's hepatitis C genotype 1, 2, 3, or 4? Yes No

4) If the patient is currently on the requested drug regimen, please indicate start date (YYYY-MM-DD) _____

5) Indicate the name of the specialist consulted, where applicable _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to Alberta Blue Cross, Clinical Drug Services 10009 108 Street NW, Edmonton, Alberta T5J 3C5 FAX 780-498-8384 in Edmonton • 1-877-828-4106 toll free all other areas
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.
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